Clarifications on State MMA Data Feed – 9/15/05

Please note: These Q&A's are in addition to the 6/30/05 version; they do not replace that version.

Changes to Data Dictionary

The submission deadline, 3rd paragraph, page 3 of the Medicare Modernization Act (MMA) State File Specifications and Data Dictionary is being changed to the 25th day of the enrollment month. The 4th paragraph regarding replacement submittals must be received by the end of the month remains the same.

1) On page 33 of the Data Dictionary the field name HIC-RRB-IND-REC should be HIC-RRB-IND-ERC.

A: The field will be corrected.

2) In the 6/30/05 MMA Data Dictionary specifications for the response file, the two "Cross-Reference" occurrences are indicated as numeric: 9(09) and 9(02). Should they be alphanumeric?

A: Yes, the Cross Reference Number (10 times) position 0336 - 0445 should be alphanumeric: The correction is to format, XREF BENE CLM ACCT NUM will be changed to X (09) and XREF BENE IDENT CODE will be change to X (02).

3) On page 30 of the data dictionary, for dual status code, it has the statement "Medicaid drug coverage criterion only applies through December 2005". This statement is there for 02, 04, 08s. Why? Won't we still need to tell you after 12/05 which recipients would have been 02, 04, and 08s? Are we misunderstanding something?

A: Yes, states will need to continue to populate DUAL STATUS CODE with 02, 04, and 08 for full-benefit dual eligibles. In the description of the DUAL STATUS CODE data element, the language on drug coverage was a holdover from the initial Data Dictionary, in which we thought the MMA file would replace the discount drug card file. The descriptions will be changed to:
02 = Eligible is entitled to Medicare – QMB AND FULL Medicaid
04 = Eligible is entitled to Medicare – SLMB AND FULL Medicaid Coverage
08 = Eligible is entitled to Medicare - Other Full Dual Eligibles (Non QMB, SLMB, QWDI or QI) with full Medicaid Coverage. The "including RX and (Medicaid drug coverage criterion only applies through December 2005) will be eliminated.

CMS' Response File

4) The return file has now been defined in the State File Specifications and Data Dictionary (6/29/05). There is a group of "non-entitlement" single letter codes for Parts A and B. We believe these are currently in use but we do not have a very complete explanation of their meaning. Is there a source for obtaining more detailed information about the codes?

A: Please see below.

THE FOLLOWING CODES OCCUR WHEN THE PART A ENTITLEMENT DATE IS PRESENT AND THE PART A TERMINATION DATE IS BLANK:

E = FREE PART A ENTITLEMENT
G = ENTITLED DUE TO GOOD CAUSE
Y = CURRENTLY ENTITLED, PREMIUM IS PAYABLE.

THE FOLLOWING CODES OCCUR WHEN THE PART A ENTITLEMENT DATE IS PRESENT AND THE PART A TERMINATION DATE IS ALSO PRESENT:

C = NO-LONGER ENTITLED DUE TO DISABILITY CESSATION
S = TERMINATED, NO LONGER ENTITLED UNDER END-STAGE RENAL DISEASE PROVISION
T = TERMINATED FOR NON-PAYMENT OF PREMIUMS
W = VOLUNTARILY WITHDRAWAL FROM PREMIUM COVERAGE
X = FREE PART A TERMINATED OR REFUSED HI

THE FOLLOWING CODES OCCUR WHEN THERE IS NO PART A ENTITLEMENT DATE (AND NO PART A TERMINATION DATE):

D = COVERAGE WAS DENIED
F = TERMINATED DUE TO INVALID ENROLLMENT OR ENROLLMENT VOIDED
H = NOT ELIGIBLE FOR FREE PART A, OR DID NOT ENROLL FOR PREMIUM PART A
R = REFUSED BENEFITS
N = NOT A VALID SSA HOC, BUT USED BY HCFA'S THIRD PARTY SYSTEM TO INDICATE A 'POTENTIAL' PTA ENTITLEMENT DATE

THE FOLLOWING CODES OCCUR WHEN THE PART B ENTITLEMENT DATE IS PRESENT AND THE PART B TERMINATION DATE IS BLANK:

G = ENTITLED DUE TO GOOD CAUSE
Y = CURRENTLY ENTITLED, PREMIUM IS PAYABLE.

THE FOLLOWING CODES OCCUR WHEN THE PART B ENTITLEMENT DATE IS PRESENT AND THE PART B TERMINATION DATE IS ALSO PRESENT:

C = NO-LONGER ENTITLED DUE TO CESSATION OF DISABILITY
F = TERMINATED DUE TO INVALID ENROLLMENT OR ENROLLMENT VOIDED
S = TERMINATED, NO LONGER ENTITLED UNDER END-STAGE RENAL DISEASE PROVISION
T = TERMINATED FOR NON-PAYMENT OF PREMIUMS
W = VOLUNTARY WITHDRAWAL FROM COVERAGE

THE FOLLOWING CODES OCCUR WHEN THERE IS NO PART B ENTITLEMENT DATE (AND NO PART B TERMINATION DATE):

D = COVERAGE WAS DENIED
N = NO (FOREIGN/PUERTO RICAN BENEFICIARY NOT

ENTITLED TO SMI. ALSO DUALLY/TECHNICALLY
BENEFICIARY IS NOT ENTITLED TO SMI).
R = REFUSED BENEFITS

5) When can eligibility into part D end, e.g. when they lose A and B? We noticed that the response file only includes an eligibility date when the beneficiary first gets part D; there is never an ending date specific to Part D.

A: Yes, Part D eligibility ends when the person loses both Parts A and B eligibility. A start date was included because FFP ends upon Part D eligibility, not enrollment in a Part D plan (which is a separate field on the response file).

6) Can a beneficiary be eligible for Part D, enroll in Part D, drop Part D and then re-enroll in Part D?

A: Yes. A person may be continuously eligible for Part D, but enroll in a Part D plan, disenroll for a period of time, and then re-enroll at a later time (subject to valid enrollment periods).

7) What is the need for multiple segments for Part D, PDP and LIS records for a beneficiary?

A: To provide history, i.e. because beneficiaries can change plans; their copay levels may change, etc.

8) Is there is a Special Needs Plan indicator in the Return file or if we are going to be getting the PBP plan number that is particular to the Special Needs Plan. If not, how can we determine which MA plans are SNPs?

A: No, there is no unique indicator or value that shows which MA plans are SNPs. Once all the SNPs are approved with signed contracts, CMS may be able to provide each state with a list of SNPs in their specific state.

9) On the response file, how can a state tell if a beneficiary has opted out of Part D?

A: The BENE AFF DECL IND [position 2220] will be set to Y.

9a) There is a field on the return file that says recipient declined auto-enrollment. We would like a little more explanation about what we can assume from this information. Does this mean that they declined it in that month or could it be for a previous time period? If they declined auto-enrollment can we assume that they are not enrolled in any plan or could they have enrolled in another drug plan during that month?

A: When a beneficiary notifies the Part D plan they are enrolled in, or 1-800-Medicare, that they want to affirmatively decline enrollment into Part D, it means they will not be auto-enrolled. Currently the system is programmed to default populate this field to "N," so person would be auto-enrolled. If a person indicates

they want to affirmatively decline, the indicator is set to "Y" and is left that way. To re-enroll the individual need only enroll with a Part D plan; this indicator in no way prevents voluntary enrollment. The indicator will not be set back to "N." If a beneficiary has an indicator of "Y" and no Part D plan enrollment, then the state can conclude that they have affirmatively declined; if it is set to "Y" but there is Part D enrollment, the state can conclude the person decided to voluntarily enroll in a plan.

10) We notice that any Detail records in the response file having any Cross Reference HIC numbers have errors. For example, the first occurrence is always empty; the second is populated with garbage. Can this be corrected?

A: Yes, this issue had been addressed as of the July response files. If states are continuing to see this or if it reappears for whatever reason, they should notify CMS as soon as possible.

11) In the response file specifications in the MMA Data Dictionary, there is a BENE AFF (AFFIRMATIVELY) DEC (DECLINE) INDICATOR field described as follows: An indicator providing whether or not a beneficiary had chosen not be auto-enrolled by CMS in a Medicare Part D plan. What should this information be used for? Why do we need to know whether the person declined to be auto-enrolled and wants to select a PDP on their own?

A: Beneficiaries who affirmatively decline auto-enrollment may enroll on their own voluntarily, but they may also choose not to enroll. This indicator will explain to states why a full-benefit dual eligible does not have a Part D plan (i.e. declined to be auto-enrolled, and did not enroll on his/her own).

12a) Can CMS provide a crosswalk of managed care plan contract numbers and 3 digit PBP numbers with plan names?

A: No crosswalk exists currently with this information. However, states can access HPMS for this information as identified in the 6/30/05 Q&A #75 copied below. Please note the list is not static.
75 Response File

12b) How do States find out more detailed information about the Medicare Advantage plans and PDPs in which beneficiaries are enrolled?

A: Health Plan Management System (HPMS) is a web-based system. It is accessed by all the Medicare Advantage managed care plans when they enter/update their annual plans and packages and then it is accessed by many other entities to look up information about the plans. It will include PDP data as well. States have the option to request access to this system so that they can pursue the more detailed information on PBPs, for example. However, they must first contact Don Freeburger (CBC) to set up access. His phone is 410-786-4586, his email is donald.freeburger@cms.hhs.gov.

13) Can CMS send states a list of records of ineligibles not previously reported identifying those individuals?

A: No, we are not allowed to e-mail any identifying information from the files so we cannot give you a specific list of individuals. However, we can explain how they were possibly identified as added ineligibles. The retroactive records were matched by Mathematica to the records on the original file based on SMA_ID, HIC, and SSN. If a person cannot be matched on all three of these elements, it is assumed that the retroactive record is adding a new person to the file and not making a correction to an original record. They were identified as ineligible because the Medicaid eligibility status for these individuals was coded as "N." In this situation, it is possible that these persons were included in the original file. In a subsequent submission, a state submitted retroactive records changing their eligibility status to indicate they are no longer eligible. However, if the State had changed the SMA_ID, HIC, or SSN information in the retroactive records for these individuals, MPR would not have been able to match the original record with the retroactive record and these persons would be identified as new records with non established eligibility. To improve the process in the future, Mathematica has changed the match criteria to only match on SSN and DOB. This will be effective for the September reviews. This is the first Mathematica scenario for marking ineligible retroactive records as invalid.

In the second, a record may be erroneously considered as being an invalid retro ineligible record if a state established this client's eligibility thru a retro addition instead of thru a current file submittal. In this case, Mathematica would not have looked at the retroactive eligible record to match them with the subsequent retro ineligible record and thus the invalid ineligible situation would be triggered. This logic will also be altered beginning with the September reviews.

To remove clients with previously established eligibility, please submit retroactive records for the affected months with the dual code 9-filled and Medicaid eligibility marked as 'n'. This will remove them from the file for the months in question.

14) If we submit a record on someone that we think has Medicare A or B and CMS determines that they do not have either, what fields will be completed on the response file? What Record Return Code will we receive? I assume the Medicare Part A/B Finder Code will be coded a 1 ("The person had neither Medicare Part A nor Medicare Part B."). However, a 1 is also displayed in this field for individuals that do not match because of errors such as birth date. It appears that there is maybe a different Record Return code or some other way for us to identify individuals who do not have Medicare versus individuals who have Medicare but we have an error in our data. Can you help us with this?

A: Yes, we will send back a 1 in the Finder Code field, and we acknowledge that there is a need for more detail level return codes. We are currently looking at additional codes to better describe the situation.

15) If an individual has drug coverage under a Medicare Part C plan, will the MMA Response file show anything under Part D? If the response file does not display enrollment info under Part D, how will we know that the person does not need to enroll in Part D plan because their drugs are provided under their Part C plan?

A: A person enrolled an MA-PD plan, or a cost plan with a Part D optional supplemental benefit, will have data in the Part D elements of the state response file as well as the Part C elements.

16) Are there regulations in place concerning how states may use the response file data? If so, what are they? Our basic question is: are we allowed to keep historical versions of the file and if so, how many? Are we allowed to keep a master file of the data? We are asking this because it is our understanding that some files like the Bendex and possibly the EDB have laws that do not allow a 'system of records' (master file). The purpose for keeping these historical files would be to answer client calls, perform budget reconciliation, and work error reports on mismatches.

A: It is CMS data and they would have to follow the rules and regulations for use of CMS data. They can keep it for a reasonable amount of time for the purpose it was released to them but they cannot use it for other purposes without our permission.

17) On our July response file, we noticed that the Part A and B entitlement fields were not populated. Is there a reason why there is no data?

A: Depending on the status of the client, no entitlement dates may be present, yet a status code indicating the absence of one or the other may. Please see Question #4 above for possible code values.

18) In the MMA response file there will be a contract number and plan ID. Is there anything about those data elements that will imply PCN and Bin numbers that indicate to pharmacists where to send a claim? There have been lots of conversations about the need for us to have this information but we are not sure where we would get it from.

A: We will investigate, in the future, the possibility of independently providing the PCN and BIN number of the Medicare Plans and PDB. Please note that the information would be available to the pharmacy by the pharmacy submitting the NCPDP eligibility query or it is envisioned that the States should be able to obtain the information from the eligibility match through the Medicare Coordination of Benefits Contractor (COBA).

19) How will the names of the Part D organizations be associated with the "Beneficiary Contract Number"?

A: States will need to access CMS' HPMS system to obtain plan name. Please see Question 12 above.

20) On the response file layout in the CMS MDB File area, there are two fields BENE CLM ACNT NUM X (9) and BENE IDENT CD X (2). Staff here interpret this as being the same as the HIC and BIC, but in every other system we have the BIC portion is 3 characters and are alpha-numeric. In addition, further down in the CMS MDB file layout are two more fields that would look to be the same but are defined as 9(09) and 9(02) which mean numeric only, and staff here believe the BICs may be alpha. In all other file layouts the HIC has always been 12 characters.

A: The RRB, before CMS converts it, can be up to 12 positions (hence the 3 position "BIC"). However, the numbers we are returning to the states have been converted and equated and will not exceed 11 positions, which is why we can use the 9 plus 2 layout. The fact that we describe the 11 positions as numeric is something that we have already changed to be alphanumeric.

21) To delineate the two fields "BENE CLM ACNT NUM" and "XREF BENE CLM ACCT NUM," can we assume that BENE CLM ACNT NUM is the active number and the XREF BENE CLM ACCT NUM (10 occurrences) are the inactive/HX references only?

A: XREF BENE CLM ACCT NUM numbers are the Inactives.

22) In the response file there is SSN information with 5 occurrences. Is there any order of the occurrences that needs to be understood?

A: The SSN sequence is that the 1st occurrence should represent the most recent.

23) What is the difference between the MAILING ADDRESS fields and the RESIDENCE ADDRESS fields? Does the field BENE REP PAYEE SW field need to be used in conjunction with these fields to make sense if there is a difference?

A: The mailing address is the address of record in our systems. If a person has a representative payee, that representative payee's address is what will populate the mailing address. The BENE REP PAYEE SW will alert states as to whether or not the beneficiary has a representative payee. Currently, we do not populate the residence address fields.

24) Are we correct that a dual once sent on the MMA file will be auto enrolled in a PDP? If the auto-enrollment process is done after you receive our MMA file and we get a response file, can we get that information earlier than the following month?

A: The person will be auto-enrolled in a Part D plan. At this time, we do not have the means to get these data to the state earlier.

25) Some of our Medicaid recipients have Medicare Part C (HMO-Medicare Advantage plan). From a few sources it looks like many on those Part C plans will make recipient ineligible for Part D. How will we know if the Part C covers drugs?

A: Full-benefit dual eligibles in Medicare Advantage plans will be auto-enrolled into an MA-PD plan in that same organization to ensure they have access to the Part D benefit. If a beneficiary is enrolled in an MA-PD plan, the same data (contract number, etc.), will appear in the Group Health Organization data elements (for Part C enrollment, positions 1463-1672), and Part D Plan Benefit Package (positions 2401-2650).

26) Will CMS provide, on either the regular response file or the one-time data file to be received in early October by the states, the individual's claim number that will be assigned by the PDP in which they are enrolled? Will there be any fields designated for the individual's claim number or policy number with their PDP?

A: No, this number will not be provided.

27) Will the fields in the "original detail record" be exactly what the State sent on the MMA State file or would there be cases that one or more of the fields would have been changed? If yes, under what circumstances would an original detail field change?

A: The fields will be the same as what the State submitted.

28) For individuals that are identified on MMA State return files (one-time October auto-assignment or MMA state response) as eligible for Medicare Part D - will the state then need to report them on the monthly MMA State file to CMS?

A: Yes, the state should submit a full replacement file, not just accretions and deletions, each month.

29) Regarding the response file, please clarify what the Contract number and the PTD PDP ID will mean to the states.

A: The Contract number (BENE CONTRACT NUM) and PTD PDP ID (BENE PTD PBP PLAN ID) will identify the number of the PBP plan. States will need to access CMS' HPMS system to obtain the Contractors (Plan) name. See #12 above.

30) Where will the States get the cross walk of the Part D Contractors and the PDP numbers?

A: States will need to access CMS' HPMS system to obtain the Contract's (Plan) name. See #12 above.

Low Income Subsidy (LIS)

31) It is my understanding (per our Regional CMS) that Medicaid beneficiaries who meet their spend down in the months of 3/05 through 12/05 will be deemed LIS for calendar year 2006. The enrollment file instructions are that the states should not be reporting retroactively eligible beneficiaries before 6/05. If states are to only go back to the 6/05 date for reporting retroactive eligibility on the Enrollment file, how will any beneficiaries that meet their spend down between 3/05 and 6/05 be reported?

A: For the period of March-May, 2005, CMS identified those to be deemed for LIS from a combination of discount drug card files and the third party buy-in system. In general CMS prefers that no retroactive MMA records be sent for period prior to June, 2005, because the validation files during that period were not retained, and there is nothing to "correct." In the case of this question, however, states are welcome to submit retroactive records to add individuals who would not otherwise have been reported on the discount drug card file or third party buy-in file.

32) What is the eligibility begin and end date for LIS? Is it a yearly determination with a start date of 1/1 of the year and end date of 12-31 of that same year?

A: It starts the first of the month in which they are eligible to be deemed, and ends 12/31 of that year. For example, a Medicare person who becomes Medicaid eligible May of 2006 will be LIS deemed for 5/1/06 to 12/31/06.

33) Can Institutional Status be coded "Y" when an individual has been confined in a medical facility for 30 consecutive days. For example, 20 days in an acute care hospital and 10 days in a nursing facility.

A: No. Section 1902 (q) of the Act defines "institutionalized individual" as one who is an inpatient in a medical institution or nursing facility for which Medicaid makes payments throughout the month, and who is eligible for Medicaid. Because Medicare pays for the first 60 days of acute hospitalization, Medicaid would not be paying throughout the month.

34) Per the LIS guidance issued on 5-25-05, SSA should be providing 'leads' info on LIS persons who may be eligible for the MSPs. It is my understanding now that SSA will provide the info to CMS, who will then inform the states. Do you have any idea what format this data file on "leads" will be? Our programmers are hoping it is "MDM." Do you have any idea when this will start to be sent? Are there any data specifications available as yet?

A: CMS is working on the implementation date of the leads data. The newly expanded leads data elements are:

- Beneficiary's Name
- Social Security Number
- Health Insurance Claim (HIC) #
- Date of Birth
- Sex
- Subsidy Approved (Y/N)
- Subsidy Approval/Disapproval Date
- LIS effective date (first day of the month of application)
- Resources over or under LIS limit
- Income used for determination (individual/couple)
- Income as a Percent of Federal Poverty Level
- Denial reason (no Medicare, not in USA, failure to cooperate, resources to high, income too high)
- Mailing address

This data will not contain dollar amounts of income or resources.

35) In the LIS section of the MMA file, for the Appeal field, can this be blank if there is no appeal? What is entered if appeal is filed? Is Y or N response for result of appeal?

A: Enter "9" if there is no appeal. The default value for the RESULT OF AN APPEAL field is 9, blank should not be submitted.

36) For the LIS section of the MMA file, please clarify if states need to send pendings and rejects. If we send these do we use 9 for approval, start, end and subsidy code field?

A: States should not submit pending cases. LIS denials should be submitted.

Populating Fields

37) When a state submits a record with ELIG STATUS=N, is it correct that they do not need to fill in the dual status code with "9"?

A: Yes. Q&A #83 from the 6/30/05 version was in error. When a States submits a retroactive record to terminate a previously submitted enrollment record, the State may include the dual status code that was originally submitted.

38) If a state needs to retroactively correct SSN, what fields in the enrollment record need to be populated?

A: In general, we would like to see a correction retroactive record adding the new SSN, and retaining all other field values. In processing a retroactive correction to an existing enrollment, CMS overlays the new data upon the old data. We don't check each field of the enrollment record to determine where the change has occurred. If the state is submitting a retroactive enrollment record to update an

enrollment they had already sent to us, they should supply all data values as they would for a new enrollment.

39) We discovered on our retroactive records that we set the DRUG COVERAGE IND to '1' on all retroactive records, even the ones that should have been '0'. What is the impact on auto-enrollment?

A: The drug indicator is not used in auto-enrollment. Auto-enrollment instead uses DUAL STATUS CODE to identify full-benefit dual eligibles. In fact, the DRUG COVERAGE IND was only included because it was initially thought it would be necessary for discount drug card purposes. That did not become the case, so states to not need to submit retroactive records solely for the purpose of correcting the drug indicator.

40) Can institutional status be reported as unknown for retroactive records?

A: Answer Pending

41) Should individuals who have not met their deductible and are on buy-in, and whose income is over the SLMB limit but below the QI limit, be included on the MMA file? If yes, dual status code 06?

A: Please explain “have not met their deductible”. Is this the Part D deductible? Otherwise the answer depends on the basis for the state’s buy-in. If the individual is not recognized as QI by the state, what is their MSP status? If the individual is QDWI, they are not deemed eligible for the subsidy and would have to file an application.

<u>Phasedown Contribution</u>

42) Will states be billed for records with the record return code of 000006? Do states need to submit a record on the following month’s file to delete the record coded 000006?

A: We do not count duplicate records towards billing and they will not be loaded into our tables. The only record that will be counted as well as loaded into our data tables is the last VALID record. Thus there is no need to send in a retro deletion record. Please ensure that this submitted record truly was to have been a duplicate (code 000006), other wise a corrected record would need to be submitted.

43) Is there a data field on the response file that will tell us by recipient that they are included in the clawback? One would assume recipients coded 02, 04 and 08 but what if they didn't match? This would throw the numbers off so we can't just rely on them being a 02, 04 or 08 it would seem. Is there another way to tell?

A: Currently the response file will not reflect the individual clients who you will be billed for, however, we are working on a possible enhancement that may (IF

implemented) show record by record whether or not the state was billed for the client or not.
However, at this point you are correct in saying that we only include clients with Dual Status codes of 02, 04 or 08 in our calculation, and only IF this record was successfully matched to our databases. Thus a full dual, who for some reason, we did not consider a match for the submitted month, will not be included in the billing.
Yes, we definitely need for you to indicate if a client is dually eligible and indicate the corresponding codes (parallel to MSIS), even if as of 1/2006 "Medicaid drug coverage criterion" definition no longer applies to the dual codes of 02, 04, and 08, they are still considered full duals.

See the response in question 44 below that will describe the fields used for the clawback amount.

44) Will the state get a separate file on or about the time we get the bill for the phased down state contribution that provides billing detail like the buy-in files for Part A and B or will the Part D return file expand to include these elements?

A: The MMA system does not presently provide the State with beneficiary level charge/credit information. The fields used for the calculation of the monthly bill are found in each of these summary records:

- In the Summary Record we use a "CALCULATION SWITCH" (Y or N) to indicate if a given Eligibility month was used (would normally always be Y), then the fields that will be send to create the bill will be :
    - NET TOTAL VALID FULL DUALL ENROLLMENTS (representing your debits for that particular month) as well as
    - NET TOTAL VALID FULL DUAL DISENROLLMENTS (representing your credits for that month).

Thus each month represented in the file you send us will be represented on the bill in the forms of corresponding debits and credits.

45) If two states have the same individual on their files, how does CMS choose which state to enroll the person in Part D and charge the phase-down contribution to?

A: The person is enrolled in the state that is on file in address data in CMS' systems (which is populated by SSA).
In regard to the phase-down process, records will be counted for any State that submits a successfully-matched record. To the extent that this has a significant effect, the differences in utilization for these records should be reflected in the baseline average per-capita drug payments.

46) For purposes of both clawback payment determination and LIS deeming, the state is required to report dual eligibles retroactively for a period yet to be determined. I can understand where this can be a real benefit to someone who has been enrolled in a part D plan prior to the Medicaid application as it will allow them some reimbursement for

previously paid out of pocket drug costs that the subsidy would now cover. Will we also be required to report any retroactive months for those individuals who have not been enrolled in a Part D plan? Medicare will not have any costs associated with this individual for those retroactive months.

A: Answer Pending

47) Will the state need to pursue estate recovery against individuals for the Part D "clawback"? The Part D final regulations only addresses estate recovery for the MSP's, and does not address the clawback as it relates to estate recovery. It is our understanding that, if it is possible to associate a specific amount to a case, federal law permits us to include the amount in estate claims and our state law requires it. As you know, the clawback payments will be paid on a per person basis.
A: Answer Pending

Date of Birth /Mismatch Problems

48) CMS has received a number of questions on this issue, such as:

- We are having difficulty interpreting the non-matches summary information in our MMA Enrollment Return file. Please clarify which identifiers or combination of identifiers are used for matching against the Medicare Beneficiary Database. Please confirm that "not located with HIC or SSN" indicates the count of valid records that were not successfully matched. Please describe what "located but failed scoring" indicates. Within this category, there are several subcategories; e.g. "failed scoring + bad SSN"; "failed scoring + bad birth day"; "failed scoring + bad birth month"; etc. Please describe the specific conditions/values which cause detail records to fall into each of these subcategories. Our state's May return file includes several hundred records in the various "failed scoring" categories, but no indication from Error Return Codes (ERC) section of the file that any of the records are invalid based on what we presume to be the relevant ERC fields. Moreover, we are puzzled by what we are seeing in the Record Identifier ERC field: apparently the number of non-matched records is equal to the number of these records populated with '01' (Invalid)--which we don't understand since we have confirmed that all of the records in the returned Record Identifier field are populated with "DET", a valid value. We also don't understand how it relates to "failed scoring". The State needs to be able to pinpoint the specific issues that cause records to fail the matching process in order to efficiently correct erroneous data.

Example of Date of Birth Mismatch as it appeared on one state’s response file:

RECORDS IN : 000151900
RECORDS OUT : 000151900
TOTAL DETAIL RECS: 000151898
RECORDS MATCHED: 000151260

RECORDS UNMATCHED: 000000638
MULTIPLE MATCHES: 000000000
INVALID RECORDS: 000000000

****
NOT LOCATED WITH HIC OR SSN: 000000000
LOCATED BUT FAILED SCORING: 000000638
****
FAILED SCORING + BAD SSN: 000000438
FAILED SCORING + BAD BIRTH DAY: 000000283
FAILED SCORING + BAD BIRTH MONTH: 000000275
FAILED SCORING + BAD BIRTH YEAR: 000000275
FAILED SCORING + BAD SEX CODE: 000000041
FAILED SCORING + BAD CAN NUM: 000000008
FAILED SCORING + BAD BIC CODE: 000000001
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- We are trying to understand the MMA Return File and are having some problems. All of our "error" cases had a Record Return Code of 03 and a Medicare Part A-B Finder code of 01. As I read the instructions, this means that they were not found on the Medicare Entitlement File. However, some of the records we show have been accreted for the State to pay their Part B premiums and we are, in fact, being billed and are paying them. On these we cannot determine what needs to be corrected and I am concerned about them receiving their drug coverage if the interface continues to fail.

- We are also finding that approximately 60% of the error cases are SSI recipients. For these cases the demographic information comes to us from SSA and we do not have a way to correct them. Do you know what we are to do about these? I have referred this same issue to SSA in our Dallas Regional Office but have not received a response.

- If I'm reading this right, a DET record fails when there is no match among HIC/RRB#/SSN/DOB but there is no message (or combination of messages) to tell us that. I think it would be helpful to all of us to know that/why a record fails so that we can do data correction.

  A: If there is no MBD data and each individual Error Return Codes field contains the value 00: Value is Valid then the State would always interpret the missing data as there is a mismatch on DOB.

  At this time, the MBD does not capture the scores of the match algorithms on each record, or the specific components of the overall match process. Therefore, the system is not now designed to identify those records that failed the match solely because of an unmatched DOB.

The message "not located with HIC or SSN" shows that there is no match on the identifiers. After a match is made on one of the identifiers, CMS checks the month, day and year of the birth date and the sex. A match on each component counts for a certain number of points. If we do not get a match on enough of these four checks, the record is marked failed scoring. One record could receive several error messages if more than one field failed. One the detail record itself, we do not mark the scoring, just that the record failed. Please see the field definitions for Records Valid in the CMS return header record, and Record Return Codes in the CMS return detail record in the attached document. They provide more explanation.

States obtain some beneficiary demographic information from the SSR system. The DOB on this system is occasionally not consistent with the MBR, which is the SSA system of record and which feeds the Medicare enrollment databases. State records are failing the State MMA data feed match because the DOB is incorrect, even though they received this information from SSA. This results in denial of LIS and auto-enrollment for eligible beneficiaries, as well as undercounting duals for the Phasedown calculations.

CMS recommends that every unmatched record returned to the State be submitted to one of SSA's correction processes to obtain a corrected birth date, if available.

Suggestion use SVES to obtain the DOB of record for SSA and CMS as follows. If the State inputs a record with an incorrect DOB, SSA gives them an indication that they did not verify the SSN because of the DOB, but SSA does give them the correct DOB. States would need to then re-query the record using the correct information.

As part of a long term project CMS will investigate the possibility of providing an error message that would indicate a DOB mismatch.

49) What is being done to bring the SSI data in line with the EDB data? It is reasonable for a state to expect that one individual would have one name, one date of birth and one primary SSN. Has CMS taken any steps to work with SSA on this problem? What steps, if any, is SSA taking to address the current cases as well as preventing future problems?

A: CMS has been actively working with SSA to address the difference between SSR file used for SSI and the MDB file used for the MMA data matching process. However, this will be a long term project. Please refer to # 49 above about suggestions the States may pursue to address the data differences in the meantime.

<u>Error Return Codes on CMS' Response File</u>

50) Several ERCs (Error Return Codes) have the message copied below. What's not clear is how the return file will show that the problem is that there's a mismatch among

the DEs (Data Elements). For example, for date of birth there are several messages showing invalid dates but none showing that the DOB doesn't match the HICN, SSN, or RRB #. The ERC message is: Critical Identification field: Additionally, a detail record will be considered Invalid if it does not have one of the following combinations of identifying information:- HICN or RRB, Social Security Number, Date of Birth- HICN or RRB, Date of Birth- Social Security Number, Date of Birth.

A: The Error Return Code fields do not consider the field with comparison to other fields. It is a focused validation/consideration of only the one field. We would not have a match/mismatch indicated for the Record Identifier ERC, because the Record Identifier ERC only indicates a reflection of the value of the Record Identifier, not the match assessment of the record. If additional match/mismatch information would be beneficial/sought, we would need to further discuss/determine what would be additionally helpful.

The message "not located with HIC or SSN" shows that there is no match on the identifiers. After a match is made on one of the identifiers, CMS checks the month, day and year of the birth date and the sex. A match on each component counts for a certain number of points. If we do not get a match on enough of these four checks, the record is marked failed scoring. One record could receive several error messages if more than one field failed. One the detail record itself, we do not mark the scoring, just that the record failed.

Please see the field definitions for Records Valid in the CMS return header record, and Record Return Codes in the CMS return detail record in the attached document. They provide more explanation.

51) It would be helpful to know that/why a record fails so that we can do data correction.

A: CMS analysis has revealed that the majority of the scoring failures are due to unmatched birth dates. The cause may be data discrepancies from SSA data exchanges. CMS is urging every state to check all rejected records via the SVES system as SSA to make sure the birthdates is updated.

52) Is it possible that the birth month didn't match the birth month CMS associates with the HICN/RRB and/or SSN? If so (this goes back to the issue above), we do get summary information about failed records; but without knowing which ones failed and why, we're helpless to correct them.

A: The error codes in each detail record will show whether the birth date fields are invalid because of format or valid value issues. If there are no error codes in the detail record, but the summary error report shows a number of records with failed scoring including bad DOB fields, then the DOB is unmatched. Please see the field definitions for Records Valid in the CMS return header record, and Record Return Codes in the CMS return detail record in the attached document. They provide more explanation.

53) When I wrote last week asking about receiving data about failed records due to cross-referenced Dual Eligibles, I forgot to mention error messages such as those below. An error message such as "Invalid BIC" or "Invalid BI Code" is considerably more helpful than the current HIC ERC, "Value is not in Valid Value Set," which could mean also that the HIC is not in SSA's data base.

A: The BIC portion is not separately evaluated for validity at the current time. However, the phrase “Value is not in value set” only refers to the individual characters submitted in the HIC. For example HICs must be a prescribed length and may not contain any special characters, nor spaces. RRB coding is taken into consideration as well. The phrase, however, does not mean that the HIC has been matched successfully or unsuccessfully to CMS’ MBD database.

54) What error message are returned to the States' on unmatched records, especially the DOB mismatch (if any message is returned - in other words how does the State know what record is invalid and the reason). The error messages do not appear to identify mismatches.

A: The Record Return Code does not return a direct indication of Match or Mismatch. The Record Return Code indicates prescribed and documented reasons for the record to be Invalid or Valid. The indication of whether the beneficiary matched or did not match to the MBD is the presence or absence of MBD data.

Per the State Spec, it is documented which fields are critical for a record to be valid. If any of these fields are invalid, then the record is determined to be invalid. Additionally, it is noted per each identifying field, which identifying fields are critical to a detail record.

A match or non-match would be indicated by the presence or absence of MBD data. Whether a record was determined to be Valid and Invalid is reflected by the Record Return Code. The individual field Error Return Codes reveals which fields were found to be invalid. We do not return indication of whether or not a specific identifying field has matched or not matched to a beneficiary on the MBD. In the case of a DOB mismatch, we do not return an indication that a mismatch on DOB occurred.

55) When there is a problem with the EDB that doesn't show Medicare entitlement, and the problem is later corrected, is there a way for CMS to identify these cases? Since there is no change in the state file, currently our state system would not recognize it as a change and would therefore not send in a record for the prior member month that was rejected by CMS in error.

A: We only have the capability to edit or test the match of records based on incoming records from the State files. We cannot do an ongoing scan for updates

to past matches. Any changes would be reflected in any subsequent matches of State records after the EDB update.

When Medicaid Coverage/FFP Ends

56) Under Part D Data Elements, would you discuss the fields states should use to determine when Medicaid coverage of prescription drugs stops for dual eligibles? "Beneficiary First Eligible Part D Date" - is this the date that Medicaid can no longer cover prescription drugs for the dual eligible? Since this field does not indicate whether a person is enrolled in a Part D drug plan, must we also extract the "Beneficiary PTD PBP Enrollment Start Date" to determine the date Medicaid can no longer cover prescription drugs for the dual eligible?

A: Currently there is no Part D eligibility end date field. The state can infer that Part D eligibility has ended when Part A and Part B eligibility have both ended.

57) When a recipient turns 65 and becomes eligible for Medicare is Part D assumed or do we have to wait for a response from the MMA file?

A: Answer Pending

58) If FFP stops when Part D eligibility starts, we must deny all pharmacy claims for any dual eligible recipients as soon as we know they have Medicare Part A or B. If not we may pay pharmacy claims before we know they have Part D as that information only comes on the MMA response file. When is the first instance we will get Part D information on an existing Medicaid recipient who becomes eligible for Medicare? Currently we are notified via the Bendex and Abie systems but those systems do not include Part D information. If we wait we take the chance we will pay drug claims for folks that are Part D until we send them on the MMA file and get response and auto-enrollment information.

A: Answer Pending

59) We are having problems resolving rejects. Who can we contact to help resolve issues? If a reject cannot be resolved timely, who is responsible for prescription drugs? The State?

A: Answer Pending

60) When does the State's responsibility for coverage end and Medicare prescription coverage begin? Example-Medicare beneficiary applies for Medicaid after 1/1/06 and is not in Medicare prescription drug plan. Do states cover? Deemed eligible is a disabled individual who begins to receive Medicare after 24 months. When does state responsibility end for prescription coverage?

A: Answer Pending

61) What about those rejects in January that cannot be resolved? How do we handle dual eligibles with employer/union coverage that is as good as Medicare coverage?

A: Answer Pending

62) Regarding Medicaid recipients who enter an IMD, Medicaid coverage is generally terminated for persons between the ages of 21 and 65 who enter an IMD. Therefore, the person will probably fall off of the MMA file upon entrance into the IMD. Will the individual continue to be treated as full dual eligible for purposes of subsidy, even though we will not provide any Medicaid coverage to the individual while in an IMD? Is there an indicator on the file that should be used to communicate IMD status to CMS?

A: Answer Pending

Miscellaneous

63) Our state adjudicates pharmacy claims for several State entities (e.g. Dept. of Health, Dept. of Mental Health and Veterans). Many of the recipients in these programs have Medicare and will be Part D eligible. How do we get the information about their Part D eligibility? Can we send records on the MMA file for these folks but just indicate their dual status as "00"? This will get us the match to the MDB and give us Part D information to support our claim processing.

A: The non-Medicaid duals are not to be sent in the MMA file.

64) Would we be able to send our full Medicaid eligibility file (1 million records) to test for Part D on an annual, quarterly, monthly or weekly basis to get information on Medicare Part D eligibility?

A: No, the MMA file submission processing would reject it for failing to meet a match rate of 90%. We understand the state's interest in identifying a way to find out about their beneficiaries' Medicare status in a timelier manner, and we will look into options for doing so.

65) The PDP's are required to retain enrollment materials and information for a 10 year period. Will states be required to keep our data files for 10 years? If not that long, what are the retention requirements for data files for states?

A: Answer Pending

66) CMS' August 29 press release identifies PDP region 25's weighted average premium as $32.86, and that we also have info that we will have as many as 4 plans with premiums under $20, 5 under $25, 6 under $30. We were also informed that some of the 'enhanced' plans will have premiums under $30. Our question is, if a full dual eligible chooses one of the enhanced plans, will he/she be required to pay some part of the premium, because it is an enhanced plan, even if the premium is below the regional average? Or, can they

choose the enhanced plan without paying the premium difference, since it is below the region's average?

A: The weighted average premium in the 8/29 press release is not the same as the low income premium subsidy amount for Region 25, which is $33.11 (please see our website at http://www.cms.hhs.gov/healthplans/rates/ for a list of LIS amounts for each region). While CMS will not auto-enroll into an enhanced plan, full-benefit dual eligibles are free to choose them on their own. In region 25, CMS will only subsidize up to $33.11 of the premium, regardless of whether it is a basic or enhanced plan. If a full-benefit dual eligible enrolls in any PDP, even one with an enhanced benefit package, with a premium over $33.11, the beneficiary is liable for the balance.

67) We have children in a Medicaid expansion program; that is, although they are S-CHIP-funded, they are considered Medicaid. For MSIS, they are all mapped to Dual-eligible code '00'. My understanding is that CMS has approved this map. Because they have DE code '00', we do not report them on the dual-eligible file we send for MMA, correct? Will Medicare pay for their drugs and therefore there will be no FFP if we pay for them? If the answer to that is "yes," don't we need to include them on the MMA file if they have Medicare? If so, what DE code do we use? If the answer is something other than '00', do we need to change the map for MSIS so that the files conform to one another?

A: Answer Pending

68) CMS had previously indicated that there is FFP for SCHIP children, and we take that to include M-SCHIP children. One answered that SCHIP people are not entitled to Part-D, while the other answered that they are entitled. Please clarify which is the correct answer.

A: Answer Pending

69) Some Medicare /Medicaid individuals reported they did not receive their letter from CMS about their deemed status. They were on our file in March; they were also not on reject file. How do we validate they are on your file?

A: The beneficiaries who received deemed notices in May and June were identified in state discount drug card files and third party buy-in files in March. Beneficiaries who appeared on state discount drug card files and third party buy-in files in April and May and on state MMA files in June or thereafter will appear on the deemed file starting in October and receive their deemed notices at that time.

70) Please provide an explanation of the process for persons retroactively approved for Medicare Parts A and B. How will Part D occur? How will duals be treated?

A: Individuals who become entitled to Part A or enrolled in Part B for a retroactive effective date are Part D eligible as of the month in which a notice of entitlement to Part A or enrollment in Part B is provided (42 CFR § 423.30 (a) (3)).

71) What is CMS' criteria for determining duplicate records?

A: A record is determined to be a duplicate if it has the same ELIGIBILITY MM/YY , the same HIC and/or SSN as the prior record(s). These records will then be marked with a '00006' in the Record Return Code.

72). When we correct SSN and person is now ineligible, our system sends a change to provide the change in SSN for the recipient ID and for the change in eligibility for the prior member months. Is this correct? If not, would like suggestions from other states on what they are doing.

A: The question really is if CMS was able to match the recipient's record using the HIC initially. If this is so, and retroactively it is discovered that the associated SSN was incorrect (AND the recipient became ineligible?) it would be correct for the state to send in a retroactive record, with the original HIC, the corrected SSN, a value of "N" in the Medicaid eligibility status code, a "99' in the dual status code as well as all previously populated fields (constituting a complete record) . If the recipient was not successfully matched with the HIC, and the recipient has now become ineligible for that prior month(s), there exists no need to submit any retroactive record, since eligibility had not been established at all for that recipient, for that month/those months (because of the non-match).

73). Part 1: Please confirm that the current (up to the day) EDB file is used for the MMA data match. We submit a monthly buyin file (not daily as do some states). If we submit the buyin file in time to have the MBR and EDB updated for the M BICs to show the Part B coverage, the records will show a match. If the buyin record hasn't updated the MBR and the EDB, the Medicare will not show and it will show as an unmatched record.

A: We can confirm that the MMA match process uses the most current available (updated nightly) MBD database.

Part 2: Since our system shows the Medicare, it won't appear as a change for the next month to re-send the prior month. Does CMS have a mechanism to go back and pick up that prior month once the Medicare entitlement is added to CMS or is CMS expecting the state to develop a mechanism to re-send unmatched records that would now be matched following the update of the EDB?

A: CMS does not have a mechanism in place that would re-match unmatched records after particular updates occurred. The system only responds to records sent in by the state for the given month. A state would have to re-submit any

records not matched in the previous month in order for them to be matched against any updates that might have occurred in the interim.

74) Will there be a downloadable set of data providing states with formularies for all plans?

A: The State would need to contact each Plan or check with Plan's website.

Additional FFP Related Issues

76) Does a State need some sort of waiver to perform retroactive billing of drugs paid for by Medicaid because of a lag in Part D eligibility information or plan changes?

A: Answer Pending

77) We send a monthly EDB match file to CMS and the CMS response file documents that a client is not a full benefit dual and not enrolled in LIS/PDP. May a State bill FP for prescription drugs it provides for this individual for the month in question?

A: Answer Pending

78) We send a monthly match file to CMS and the file contains retroactive records for individuals who have established eligibility for Medicare for prior months. May a State bill FP for prescription drugs provided in the retroactive period prior to the individual's enrollment in LIS and a PDP?

A: Answer Pending

79) The CMS response file indicates the recipient is a full benefit dual, but not enrolled in the plan. May the state bill FP for that recipient for the month as they do not have Part D coverage?

A: Answer Pending

One-Time PDP Notification File

80) Will there be test files available?

> A: No, there will be no test file. The file will be sent once in October, it will be of the same format as our monthly response file.

81) On the one time enrollment file, we could really use the state's prime ID for the client, which we are populating in the SMA identifier field. All of our files are keyed based on the prime ID. Is there any way that field will be sent populated on the October one time auto-enrollment file? 1. Is there any possibility that CMS could return the SMA id on the One-time Auto-Assignment State file? Currently the file layout shows this field as compressed. It would be extremely helpful for us to have it returned.

> A: Unfortunately, we cannot accommodate this request, as we do not capture the SMA data in our system. Each state will be sent the information based upon CMS/SSA residence address.

82) This is a request for clarification. Please confirm which positions of the MMA State Response File will be used to communicate Part D auto-enrollment data on the One-Time State Auto-Assignment Notification File (MMAASTA). A letter to State Medicaid Agencies says "the first 117 positions and the data in positions 2212 through 2650 will have data. However, the file layout document indicates data will be sent in positions 237 – 1089, and 2212 – 2238 and 2401 – 2425. The 2 documents have similar descriptions for the positions containing enrollment data, but differ in the positions that will be used for the identifying data (001 – 117 versus 237 – 1089).

> A: The correct positions are those in the file format itself (237-1089, 2212-2238, 2401-2425), rather than those indicated in the introductory cover note.

83) We have been told that CMS intends to send information on Part D enrollment to states in October, but the original announcement specifically indicated that it would NOT include information on clients who are enrolled in a Part C plan, including those that opt to offer Part D.

> A: We already provide it each month on the CMS response to the MMA state file. See files for "Group Health Organization" and "MBD Plan Benefits Package Election" in positions 1463-1962 (p. 20 in MMA Data Dictionary, on our website at: http://www.cms.hhs.gov/medicarereform/states/state_filespec_data.pdf. For information on how to get plan name (the response file just has plan ID numbers), please see #12 above regarding accessing the Health Plan Management System (HPMS).